DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
					R		
		445154	B. WING			06/	10/2019
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY		
QUALITY	CENTER FOR REHA	ABILITATION AND HEALING LLC			EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENT	rs	{K 0	00}			
		p survey conducted on viously sited Federal een corrected.			=		
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: TN9505

May. 24. 2019 4:23PM Quality Center

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 P. 13 PRINTED: 05/09/2019 FORM APPROVED OMB NO. 0938-0391

> (X3) DATE SURVEY COMPLETED

AND PLAN OF CORRECTION

445154

B, WING

05/06/2019

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY

QUALITY	CENTER FOR REHABILITATION AND HEALING LLC		932 BADDOUR PARKWAY LEBANON, TN 37087			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE		
K 000	INITIAL COMMENTS	K 00	0			
	Stories: 1 Construction Type: NFPA Type V(000), V(111), II (222) limited plans on site Constructed: 1960's + Sprinklered: Yes	74.0	3 5 6 2 5 7 KKK X 30 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5) (Sec.) and		
	A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 05/06/2019. During this Life Safety Survey Quality Center for Rehabilitation and Healing was found not in substantial compliance with the requirements for participation in Medicare/Medicaid with Title 42 CFR Subpart 483.70(a), The Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-06 Standards For Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).					
	* All damaged, painted, or corroded sprinklers shall be replaced in accordance with NFPA 25, Standards for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition).	GI	(a)			
	*All sprinklers deficiencies shall be corrected in accordance with NFPA 13, Standards for the Installation of Sprinkler Systems (2010 Edition) and/or NFPA 25, Standards for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) Egress Doors CFR(s): NFPA 101	K 22:	2			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

No. 3535 P. 14 PRINTED: 05/09/2019

1: 10/19

		AND HUMAN SERVICES & MEDICAID SERVICES	, 2			APPROVEI 0938-039
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY IPLETED
		445154	B. WING_		05/	06/2019
•	ROVIDER OR SUPPLIER	ABILITATION AND HEALING LLC		STREET ADDRESS, CITY, STATE, ZIP COU 932 BADDOUR PARKWAY LEBANON, TN 37087	JE	
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETION DATE

K 222

K 222 | Continued From page 1

TAG

Egress Doors

Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:

CLINICAL NEEDS OR SECURITY THREAT LOCKING

Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.

18.2.2.2.5.1, 18.2.2.2.6, 19.2,2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used; all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location

doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4

DELAYED-EGRESS LOCKING

ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and

within the locked space); and both the sprinkler and detection systems are arranged to unlock the K222 - Egress Doors

1. Corrective Action: ADM or designee placed the missing key in the key box on the rehab courtyard wood gate. Maintenance staff inserviced by ADM or designee to ensure keys are placed within the key boxes.

DEFICIENCY)

- 2. Identifying other residents with potential to be affected: Residents in the secured unit have the potential to be affected.
- 3. Measures or Systemic Changes: ADM or designee checked any other key boxes on egress gates to ensure keys were present.
- 4. How corrective action will be monitored: ADM or designee will do weekly audits x 4 weeks of key boxes. The ADM or designee will then do monthly audits x 2 months. The results from the audits will be presented to the QAPI committee for further review. Any further issues or concerns will be addressed by the QAPI committee.

Event ID: G8QZ21

Facility ID: TN9505

If continuation sheet Page 2 of 7

No. 3535 F. 15 PRINTED: 05/09/2019

FORM APPROVED

		AND HUMAN SERVICES			FORM APPROVED MB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
445154		445154	B. WING		05/06/2019
	ROVIDER OR SUPPLIER	ABILITATION AND HEALING LLC	9	TREET ADORESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY EBANON, TN 37087	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTY)	DE COMPLETION
K 222	ordinary hazard corthroughout by an apfire detection system automatic sprinkler 18.2.2.2.4, 19.2.2.2 ACCESS-CONTRO ARRANGEMENTS Access-Controlled Installed in accordate permitted. 18.2.2.4, 19.2.2.2 ELEVATOR LOBBY ARRANGEMENTS Elevator lobby exit accordance with 7.2 door assemblies in by an approved, suit detection system are automatic sprinkler 18.2.2.2.4, 19.2.2.2 This REQUIREMENTS Elevator lobservation on observation of the findings included the findings included the findings included the rehab courty and key access and no NFPA 101, 19.2.2.2.2 The Maintenance Deadministrator was provided the rehab courty and the findings included the rehab courty and the rehab courty a	ntents in buildings protected oproved, supervised automatic of an approved, supervised system: .4 DLLED EGRESS LOCKING Egress Door assemblies note with 7.2.1.6.2 shall be ince with 7.2.1.6.2 shall be ince with 7.2.1.6.2 shall be ince with 7.2.1.6.3 shall be permitted on buildings protected throughout pervised automatic fire and an approved, supervised system. .4 N1 is not met as evidenced tions, the facility failed to ors. acted 1 of 16 smoke 32 residents. e: 06/2019 at 6:39 AM, revealed wood gate was locked with key available. .5.1 (2012 Edition)	K 222		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G8QZ21

Facility ID: TN9505

If continuation sheet Page 3 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 3535 F. 16 PRINTED: 05/09/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION L. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		445154	B, WING			05/	06/2019
NAME OF PROVIDER OR SUPPLIER QUALITY CENTER FOR REHABILITATION AND HEALING LLC SUMMARY STATEMENT OF DEFICIENCIES			ID	932	REET ADDRESS, CITY, STATE, ZIP CODE BADDOUR PARKWAY BANON, TN 37087 PROVIDER'S PLAN OF CORRECTIO	N	(XS)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE	COMPLÉTION DATE
K 353 SS=D	CFR(s): NFPA 101 Sprinkler System - Automatic sprinkle inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, inspendintained in a secondary available. a) Date sprinkler: b) Who provided: c) Water system secondary Provide in REMAR any non-required of system. 9.7.5, 9.7.7, 9.7.8, This REQUIREMED by: Based on observations on a cility failed to main This deficiency affect and all residents. The findings included 1. Observations on and 8:35 PM reveat sprinkler pendants a. RM 19 (painted) b. RM 15 bathroom c. ICF Dining room d. ICF Shower thro	Maintenance and Testing rand standpipe systems are and maintained in accordance and rothe Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked system test supply source KS information on coverage for r partial automatic sprinkler and NFPA 25 NT is not met as evidenced tions and document review the intain the sprinkler system. Sected all smoke compartments be: 05/06/2019 between 6:49 PM led painted or corroded fire in the following areas: (painted) multiple (corroded)	K	353	And Testing 1. Corrective Action: ADM or designee contractor replace sprinkler heads in 19, RM 15, ICD Dining Room, ICF Shoroom, Skilled Shower room. ADM or designee had contractor relocate sphead in ICF Dining room. ADM or dehad contractor conduct a 5 year obstruction test and an air leakage the dry pipe sprinkler system and coafull flow trip test on the dry pipe sprinkler system and dry pipe sprinkler be affected. 3. Measures or Systemic Changes: ADD designee had contractor replace sprinkler head in RM 19, RM 15, ICD Dining in ICF Shower room, Skilled Shower room, DM or designee had contractor conduct a sobstruction test and an air leakage to the dry pipe sprinkler system and coafull flow trip test on the dry pipe sprinkler system. 4. How corrective action will be monitable and the dry pipe sprinkler heads. A designee will develop a schedule for required inspections. The ADM or designee will then do monthly audit months. The results from the audit be presented to the QAPI committee further review. Any further issues concerns will be addressed by the Committee.	had in RMI ower in rinkler signee est on induct in tential in tent	2019



DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 3535 F. 17 PRINTED: 05/09/2019 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		SURVEY PLETED
		445154	B. WING		05/0	6/2019
NAME OF PROVIDER OR SUPPLIER QUALITY CENTER FOR REHABILITATION AND HEALING LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 353	NFPA 101, 19.3.5.1 101,9.7.1.1 (2012 E Edition), NFPA 25, § 2. Observation on 0 revealed a fire sprin in the ICF dining roo NFPA 101, 19.3.5.1 101,9.7.1.1 (2012 E (2010 Edition), 3. Document review PM and 9:45 PM, re a fire sprinkler obstr last 5 years on all sy was completed in 2! NFPA 101, 19.3.5.1 101,9.7.1.1 (2012 E (2010 Edition), NFP 4. Document review PM and 9:45 PM, re an air leakage test of system within the la NFPA 101, 19.3.5.1 101,9.7.1.1 (2012 E (2010 Edition), NFP Edition) 5. Document review PM and 9:45 PM, re for a full flow trip tes system within the las	(2012 Edition), NFPA dition), NFPA 13, 26.1 (2010 5.2.1.1.2 (2011 Edition) 5/06/2019 at 8:27 PM, kler within 4 inches of the wall om. (2012 Edition), NFPA dition), NFPA 13, 8.6.3.3 on 05/06/2019 between 9:00 evealed no documentation for function investigation within the systems. The last investigation 2011. (2012 Edition), NFPA 13, 24.6.1 A 25, 14.2.1 (2011 Edition) on 05/06/2019 between 9:00 evealed no documentation for on the dry pipe sprinkler st 3 years. (2012 Edition), NFPA dition), NFPA 13, 24.6.1 A 25, 13.4.4.2.9 (2011	K 35			
	101,9.7.1.1 (2012 E (2010 Edition), NFP Edition)	dition), NFPA 13, 24.6.1 A 25, 13.4.4.2.2.3 (2011 on 05/06/2019 between 9:00				

No. 3535

PRINTED: 05/09/2019

FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 445154 05/06/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 932 BADDOUR PARKWAY QUALITY CENTER FOR REHABILITATION AND HEALING LLC LEBANON, TN 37087 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 353 K 353 | Continued From page 5 PM and 9:45 PM, revealed no documentation for a dry pipe sprinkler pendant test within the last 10 years. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101,9.7.1.1 (2012 Edition), NFPA 13, 24.6.1 (2010 Edition), NFPA 25, 5.3.1.1.1.6 (2011 Edition) The Maintenance Director and Facility Administrator was present for the findings and acknowledged them during the exit conference on 05/06/2019. K 355 Portable Fire Extinguishers K 355 K355 - Portable Fire Extinguishers CFR(s): NFPA 101 SS=D Corrective Action: ADM or designee Portable Fire Extinguishers removed the cart from blocking the fire Portable fire extinguishers are selected, installed, extinguisher. Dietary staff was inserviced inspected, and maintained in accordance with by ADM or designee to maintain clearance in front of the fire extinguisher. NFPA 10, Standard for Portable Fire 2. Identifying other residents with potential Extinguishers. to be affected: No residents had the 18.3.5.12, 19.3.5.12, NFPA 10 potential to be affected. This REQUIREMENT is not met as evidenced Measures or Systemic Changes: ADM or designee placed caution tape on the floor Based on an observation, the facility failed to In front of the fire extinguisher to alert maintain the fire extinguishers. staff the area should remain clear of any storage. This deficiency affected 1 of 16 smoke How corrective action will be monitored: compartments and 0 residents. ADM or designee will do weekly audits x 4 weeks of the fire extinguisher. ADM or The finding included: designee will develop a schedule for regulred inspections. The ADM or Observation on 05/06/2019 at 8:04 PM, revealed designee will then do monthly audits x 2. the kitchen ABC fire extinguisher was blocked by months. The results from the audits will carts. be presented to the QAPI committee for NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, further review. Any further issues or 9.7.4.1 (2012 Edition), NFPA 10, 6.1.3.3.2 (2010 concerns will be addressed by the QAPI Edition) committee.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G8QZ21

Facility ID: TN9505

If continuation sheet Page 6 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

No. 3535 P. 19

PRINTED: 05/09/2019

FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SE	KAICEZ			DIVIDITIO.	0300-0301
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		PLIER/CLIA		LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY PLETED	
	,	44515	54	B. WING		05/	06/2019
NAME OF I	PROVIDER OR SUPPLIER		111	1	STREET ADDRESS, CITY, STATE, ZIP CODE		
QUALITY	CENTER FOR REHA	BILITATION AND	HEALING LLC		932 BADDOUR PARKWAY LEBANON, TN 37087		
					PROVIDER'S PLAN OF CORRECTI	DN	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	COMPLETION DATE
K 355	Continued From pa	ga 6		K 355			
1/ 333	The Maintenance D		fv	K JUL	1		
	Administrator was p	resent for the fin	dings and		1		
	acknowledged them on 05/06/2019.	n during the exit o	conference		A	<u>a</u> =	
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G8QZ21

Facility ID: TN9505

If continuation sheet Page 7 of 7

May. 24. 2019 4:27 PM Quality Center

DEPARTMENT OF HEALTH AND HUMAN SERVICES

No. 3535 P. 20

PRINTED: 05/09/2019

FORM APPROVED OMB NO. 0938-0391

CENTE	KS FUR MEDICAKE	& MEDICAID SERVICES	1		I	
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445154	B. WING		05/06/2019	
	PROVIDER OR SUPPLIER	BILITATION AND HEALING LLC	_ !	STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION	
E 000	Initial Comments		E 000	100		
195	Based on docume 05/06/2019, no Em deficiencies were c	nt review and interview on ergency preparedness ited	4/2/	a i isaaco A s		
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BORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	Admini Stator	5/33/19	

Cellrenne Suite Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued isos Androcatingation sheet Page 1 of 1 program participation.

Event ID: G8QZ21